



National Teachers Associates  
 Life Insurance Company  
 Attn: Claims Department  
 P.O. Box 2369 ♦ Addison, TX 75001-2369  
 (972) 532-2100 ♦ (888) 671-6771 ♦ FAX: (972) 532-2192

List Policy Numbers Here


## CLAIMANT'S STATEMENT

### INSTRUCTIONS FOR FILING PROOF OF LOSS

1. Complete each section on page 1 and 2 that applies, then sign and date the form on page 1. Unanswered items will generally cause a delay in processing.
2. Policyowner must sign if the patient is under age 18.
3. Have your doctor complete and sign the *Attending Physician's Statement* on page 2.
4. On a disability claim, the *Employer's Statement* and the *Attending Physician's Statement* must both be completed and signed.
5. You must submit itemized bills for each benefit claimed (e.g., itemized hospital bill, doctor bills, anesthesiologist bills, etc.)
6. All claims on cancer policies must be supported by a pathology report. (If a pathological diagnosis cannot be made, a clinical diagnosis is acceptable.)

**Warning:** For your protection, state law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

### POLICYOWNER & PATIENT INFORMATION

Name of Policyowner				Social Security Number		Occupation	
Address			City		State	Zip + 4	
E-mail address			Phone Day ( )		Cell ( )		
			Evening ( )				
Name of Patient				Patient's Social Security Number		Relationship to Policyowner	
Patient's Date of Birth	Patient's Height	Patient's Weight	Patient's Sex	Patient's Phone Day ( )			
____/____/____	ft. in.	lbs.	<input type="checkbox"/> M <input type="checkbox"/> F	Evening ( )			
Name of Patient's Primary Physician		Address		State	Zip	Phone: ( )	
		City				Fax: ( )	

### HISTORY OF PRESENT ACCIDENT • DISABILITY • ILLNESS

**IF ACCIDENT/INJURY**

Date of accident/injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ a.m. / p.m.

How did the accident/injury occur? \_\_\_\_\_

Where did the accident/injury occur? \_\_\_\_\_

Describe injuries: \_\_\_\_\_

**IF DISABLED**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_.

Date you last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_. Date released to return to work: \_\_\_\_/\_\_\_\_/\_\_\_\_.

**IF SICKNESS**

Date of sickness: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_ a.m. / p.m. When did symptoms first appear? \_\_\_\_/\_\_\_\_/\_\_\_\_.

Nature of sickness: \_\_\_\_\_

Has patient ever had the same or similar condition?  Yes  No If "Yes" give details.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_ Doctor: \_\_\_\_\_ Hospitalized?  Yes  No

Has patient been treated for anything else within the past two years?  Yes  No If "Yes" give details.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_ Doctor: \_\_\_\_\_ Hospitalized?  Yes  No

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_ Doctor: \_\_\_\_\_ Hospitalized?  Yes  No

**IF WELLNESS BENEFIT** (Attach copy of statement showing procedure and charge)

I hereby authorize any medical professional or institution, insurer, employer, government agency, The Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or of any member of my family to furnish to National Teachers Associates Life Insurance Company or its representative, any and all information with respect to employment, other insurance coverage, any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital, medical records or billing records and other medical facts that NTA Life deems appropriate to evaluate claims for benefits. A photostatic copy of this authorization shall be considered as effective and valid as the original. **I represent that the information above is true and correct.**

(Signed) Patient \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Signed) Policyowner \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# HEALTH INSURANCE CLAIM FORM

## ATTENDING PHYSICIAN'S STATEMENT

Date of First Symptom (if sickness) <b>OR</b> Date of injury _____ / _____ / _____	Date first consulted for this condition _____ / _____ / _____	Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ / _____ / _____
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Name & Address of Referring Physician \_\_\_\_\_

Name & Address of Hospital where services rendered (if applicable)	Admitted _____ / _____ / _____	Discharged _____ / _____ / _____
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Diagnosis or Nature of Sickness or Injury	ICD-9 Code
1. _____	
2. _____	
3. _____	
4. _____	

Date of Service	Place of Service	CPT Code	Describe Medical Procedures and Services Provided	ICD-9 Code	Charges

***For Disability Claims also complete this section***

**Physical Impairment** (As defined in the Federal Dictionary of Occupational Titles)

Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)

Class 2 - Medium manual activity. (15-30%)

Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)

Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)

Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

Remarks: \_\_\_\_\_

**Total Disability** means the patient is unable to perform all the substantial and material duties of their regular occupation.

Give dates of **Total Disability** (if applicable): From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If there were any dates of partial disability, please indicate: From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date patient released to return to work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature of Physician  <div style="text-align: right;">Date</div>	Physician's Federal I.D. Number	Provider's Name, Address, Zip Code
Printed Physician's Name	Patient's Account Number	Phone: (    ) _____ Fax: (    ) _____

## EMPLOYER'S STATEMENT

Date stopped work due to disability _____ / _____ / _____	Name and Address of Employer
Date returned to work _____ / _____ / _____	Signature of Official Representative: _____ Title: _____ Phone: (    ) _____ Date: _____ / _____ / _____ Fax: (    ) _____



**National Teachers Associates Life Insurance Company**  
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

**Authorization for Release of Health-Related Information**

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company  
Attn: Director of Compliance  
4949 Keller Springs Road  
Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I agree that a copy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Individual Whose Information is to be Disclosed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Individual

\_\_\_\_\_  
Policy Number